Value Alliance With Dental Benefit Guide

Administered by Anthem Blue Cross and Blue Shield
And Magellan Behavioral Health

July 1, 2003

Benefit Highlights

Value Alliance With Dental

Welcome to the Value Alliance With Dental plan for your medical, prescription drug, dental, employee assistance, and mental health coverage. This guide summarizes how the plan works and offers important information about your benefits. Your medical, prescription drug, and dental benefits are administered by Anthem Blue Cross and Blue Shield. Magellan Behavioral Health administers your employee assistance and mental health and substance abuse benefits.

This guide is only an overview. For a complete description of the benefits, exclusions, and limitations, please see the Value Alliance With Dental Member Handbook or the Magellan Behavioral Health Member Handbook.

Service Area— No Coverage For Out-Of-Network Care

Value Alliance With Dental is available wherever you or your enrolled dependents work or live within Virginia.

How The Plan Works

Network Primary Care Physicians And Specialty Care Providers

Your plan covers care provided by primary care physicians and specialty care providers. To see a primary care physician, simply visit any network physician who is a general or family practitioner, internist or pediatrician. Your plan also covers care provided by any specialty care provider you choose in the network. Referrals are never needed to visit any specialty care provider. However, higher copayments apply for specialist visits.

For the most current list of network physicians, see the Provider Directory on the Web at **www.anthem.com**. On the home page, choose Members & Consumers, then select Virginia. Click on the link for Commonwealth of Virginia and The Local Choice Members. Or call Anthem Member Services for assistance.

You are responsible for physician copayments and/or coinsurance for covered in-network services. **There is no coverage outside the network**, except in the case of a life-threatening emergency or urgent care situation.

For most covered services, you must pay a set amount, your plan year deductible, before the plan will pay its share of the cost. There is also an out-of-pocket expense limit you must meet before the plan will cover 100% of the allowable charge for in-network covered services. For a list of covered services, and applicable copayments and coinsurance, see page 4.

In addition to a higher out-of-pocket expense limit, the Value Alliance plan may contain exclusions for services that may be covered under other The Local Choice plans.

Plan Year

Your benefits are administered on a plan year basis, which **begins on July 1 and ends on June 30**. For school groups with an October 1 effective date, the plan year is October 1 through September 30.

Explanation of Deductible, Coinsurance, and Copayments

Deductible – This is the fixed dollar amount of covered services you must pay in the plan year before your health plan pays its share for covered services. You pay 100% of the plan's allowable charge for covered services until you have met the plan year deductible. The following **do not count** toward your plan year deductible: primary care physician, specialist (medical and mental health), prescription drug, and dental benefit copayments and coinsurance.

Coinsurance – The percentage of health care costs you pay for some covered services.

Copayment – The fixed dollar amount you pay for some covered services.

Plan Year Out-of-Pocket Expense Limit

Once you have met your out-of-pocket expense limit for the plan year, Value Alliance With Dental covers 100% of the allowable charge for in-network services.

What counts toward your out-of-pocket expense limit

- Primary care physician and specialist copayments
- Plan year deductible
- Coinsurance for covered services

What does not count toward your out-of-pocket expense limit

- Copayment and coinsurance amounts for outpatient prescription drugs or dental services
- Amounts above the allowable charge or any amounts that exceed specific fixed dollar benefit limits

Approval Of Care At A Glance

It's important to review and understand the rules shown below. Following them will help you use your benefits to your best advantage and minimize your out-of-pocket medical expenses.

Type of Service	Before You Receive Care
Life-threatening Emergency Care *(Such as heart attack, hemorrhaging, poisoning, loss of consciousness, convulsions, multiple or compound fractures)*	You must obtain Hospital Admission Review if admitted.
Outpatient Services Which Require Medical Review	To determine if a service requires medical review, contact your physician or Anthem Member Services. This process is also called pre-authorization. You could be responsible for the full cost of a service that requires medical review if it is not authorized in advance.
Inpatient Hospital Care (Medical/Surgical)	All hospital admissions must be coordinated by your physician and reviewed and approved in advance by Anthem. Before a hospital admission, you, your physician, a family member, or friend must call Anthem Blue Cross and Blue Shield: In Richmond: **(804) 359-7277** Outside Richmond: **1-800-242-7277** However, if your physician does not make the call, it is your responsibility to make the call. The call must be made within 48 hours of an admission for a life-threatening emergency.
Prescription Drugs Which Require Prior Authorization	Your physician, pharmacist, or Anthem Member Services can tell you if a drug requires prior authorization. Your physician may request approval for drugs that require prior authorization on your behalf. To view a list of covered drugs and see if prior authorization is required, go to the Web at **www.anthem.com**.
Mental Health Care Or Substance Abuse Treatment	Call Magellan Behavioral Health at **1-800-775-5138** for pre-authorization of care. Call within 48 hours after an emergency admission.

Medical And Mental Health And Substance Abuse Summary Of Benefits

Plan Year Deductible *(applies to both medical and mental health benefits)*	▲ Each plan year, you pay $300 per covered person, not to exceed $900 per family
Plan Year Out-of-Pocket Expense Limit *(applies to both medical and mental health benefits)*	▲ Each plan year, you pay no more than $2,500 per covered person, not to exceed $7,500 per family Once you have met your out-of-pocket expense limit for the plan year, the plan pays 100% of the allowable charge for in-network services.

You Pay (In-Network)	For Covered Services
$20 for each Primary Care Physician visit **$35 for each Specialist visit** *(no deductible)*	▲ Office visits ▲ Outpatient physician visits billed separately from the outpatient department or emergency room ▲ Maternity pre-and postnatal visits[1] ▲ Wellness check-ups ▲ Routine gynecological visit and Pap test *(one per plan year)* ▲ Physical, speech, and occupational therapy limited to 90 consecutive days per illness or condition *(medical review required)* ▲ Home and inpatient hospice visits ▲ Mental health and substance abuse visits, including outpatient and intensive outpatient services *(authorization required)*[2]
20% coinsurance after plan year deductible is met	▲ Hospital outpatient department care ▲ Inpatient hospital or emergency room medical care[3] ▲ Inpatient physician services[3] ▲ Inpatient hospital or emergency room, and partial day mental health and substance abuse services[2] ▲ Laboratory services ▲ Diagnostic x-rays ▲ Therapeutic injections ▲ Electronic tests *(EEG, EKG, etc.)* ▲ Ultrasound and fetal monitor tests ▲ Routine immunizations, preventive screenings, laboratory services and x-rays ▲ Routine mammography screening and reading ▲ Diagnostic mammography screening and reading ▲ Prostate Specific Antigen (PSA) test, men 40 and older ▲ Colorectal cancer screenings ▲ Skilled nursing home care, up to 100 days per plan year ▲ Home health care up to 90 visits per plan year ▲ Non-emergency ambulance transport *(medical review required)*

(continued)

You Pay (In-Network)	For Covered Services
20% coinsurance after plan year deductible is met	▲ Diabetes-related supplies, equipment and education ▲ Dialysis treatment ▲ Medical equipment, devices, appliances and supplies, limited to $1,000 per plan year ▲ Dental care for accidental injury

This is only a summary of your benefits. Complete information about each covered service, including exclusions and limitations, can be found in your member handbook.

[1] There is only one per visit copayment if the provider submits one global bill for all of the mother's routine pre-and postnatal care and delivery of the child.

[2] Administered by Magellan Behavioral Health. Services must be authorized in advance.

[3] Medical services administered by Anthem Blue Cross and Blue Shield. Mental health and substance abuse services administered by Magellan Behavioral Health.

Retail Pharmacy And Home Delivery Prescription Drug Benefits

Retail Pharmacy

This is a **mandatory generic** outpatient prescription drug program. If a generic equivalent exists for a brand name drug, you have two choices. You may request the generic and pay only the copayment. Or you or your doctor may request a brand name drug and you will be responsible for the following:

- **At a participating pharmacy** you will be responsible for the applicable copayment plus the difference between the allowable charge for the generic equivalent and the allowable charge for the brand name drug.
- **At a non-participating pharmacy** you pay the total price for the drug and then file a Prescription Drug Direct Reimbursement Claim Form. Reimbursement is limited to the allowable charge for the generic drug minus your copayment.

To obtain prescriptions at a participating retail pharmacy simply:

1. Present your Anthem identification card to your pharmacist.
2. Pay the appropriate copayment. The pharmacist will tell you the amount of your copayment.
3. If you request a brand name drug when a generic is available, you pay the appropriate copayment *plus* the difference between the generic and the brand name allowable charge.

Note: Some drugs require Prior Authorization before they are dispensed. See *Approval of Care At A Glance*, page 3.

Home Delivery Pharmacy

This is a convenient, cost-effective way to obtain up to a 90-day supply of medications you take routinely (such as medication for high blood pressure or high cholesterol). Your medications are delivered directly to your home. You will receive a Home Delivery Pharmacy packet with your medical identification card when you enroll in the plan. You may also contact Anthem Member Services for a packet.

Your Copayments

Prescription drugs are divided into three tiers or categories, and you pay the appropriate prescription copayment by tier. In general, the first tier covers generic drugs which are usually the least expensive. The second tier is lower cost brand name drugs and some generic drugs. The third tier is higher cost brand name drugs and may include newly introduced drugs.

To determine in which tier your prescription drug falls, go to **www.anthem.com**. Select Members and Consumers, then choose Virginia. On the home page select the link to Commonwealth of Virginia and The Local Choice Members. Then select the Prescription Drug Program link. You may also contact Anthem Member Services for assistance.

	First Tier Copayment *Typically Generic Drugs*	Second Tier Copayment *Lower Cost Brand Name Drugs And Some Generic Drugs*	Third Tier Copayment *Typically Higher Cost Brand Name Drugs*
Participating Retail Pharmacy: *Per 34-day supply*	$15	$20	$35
Home Delivery Pharmacy: *Up to 90-day supply*	$18	$33	$63

Dental Benefits—No Deductible

Plan Pays $1,200 Maximum Per Person Each Plan Year		In-Network You Pay
Diagnostic And Preventive	Twice-a-year visits to the dentist for oral examinations, x-rays, and cleanings	$0
Primary	Fillings, oral surgery, periodontal services, scaling, repair of dentures, root canals and other endodontic services, and recementing of existing crowns and bridges	20% coinsurance, no deductible
Complex Restorative	Inlays, onlays, crowns, dentures, bridges, relining dentures for a better fit, and implants	50% coinsurance, no deductible
Orthodontic Services (Plan pays $1,200 maximum per lifetime per enrolled member)	Services to correct a handicapping malocclusion (a severe deviation from the normal range of positioning of the teeth), tooth guidance and harmful habit appliances, interceptive treatment, surgical exposure of unerupted teeth when performed for orthodontic purposes, orthodontic x-rays, and orthodontic evaluations when no treatment is initiated **There is a 12-month waiting period to receive coverage for orthodontic services. Credit toward this waiting period will be given if you had orthodontic benefits under previous coverage, and that coverage ends the day before this coverage begins. In addition, orthodontic benefits paid under the previous coverage will count against the $1,200 lifetime maximum.**	50% coinsurance, no deductible
Out-Of-Network Care	For services by a non-network dentist, you pay the applicable coinsurance plus any amounts above the allowable charge. Claims payments are made directly to the member, unless the member assigns benefits to the provider.	

Using Your Dental Benefits

Claims will be handled by the dentist's office and you will be responsible only for any coinsurance, which applies to the covered care you receive. If you go to a non-network dentist, you may pay more of the bill.

To reduce your out-of-pocket expense, choose an Anthem Blue Cross and Blue Shield network dentist shown in the Commonwealth of Virginia and The Local Choice Provider Directory. View the Provider Directory on the Web at **www.anthem.com**.

Special Programs

Magellan Behavioral Health Employee Assistance Program (EAP)

The EAP provides up to four counseling sessions free of charge. Contact Magellan Behavioral Health at **1-800-775-5138** for more information.

Baby Benefits Offered Through CommonHealth

Baby Benefits is a prenatal program available at no cost to you, your spouse, or your dependent(s) through CommonHealth. This program is designed to help women have healthy pregnancies and to help reduce the chances of a premature delivery. A *Baby Benefits* consultant is assigned to women identified as having a greater risk of premature delivery. The consultant (a nurse or health educator) works with the mother-to-be and her doctor during the pregnancy to determine what may be needed to help achieve a full-term delivery. **As soon as pregnancy is confirmed, sign up for the program by calling 1-800-828-5891**. You will receive:

- a kit containing educational material on how to get proper prenatal care and identify signs of premature labor;
- a risk appraisal to identify signs of premature labor; and
- after delivery, a birth kit and child care book.

Anthem Better Prepared℠ Program

Your plan includes Anthem Better Prepared—a program designed to help you better understand and manage four chronic conditions: asthma, congestive heart failure, coronary artery disease, and diabetes. To register in this voluntary, confidential program, simply call our care management nurse consultants at **1-800-445-7922**. Enrolled members receive 24-hour access to registered nurses who can answer health questions, provide information about the most current treatment options and work with the member's physician to reinforce the prescribed plan of care. The goal of Anthem Better Prepared is to help members understand and better manage their health condition for improved quality of life.

Healthy Complements℠'

Healthy Complements gives you access to a national network of acupuncturists, chiropractors, and massage therapists who offer Anthem plan members a 25% discount for services. You may also receive preferred pricing from a national network of health clubs and fitness centers. Purchase a variety of natural health and wellness products—from vitamins, minerals, and herbal supplements to videos and books—at discounted prices. Since Healthy Complements is a service, not a covered benefit, there are no referrals or claim forms involved. More information about Healthy Complements, administered by American Specialty Health Networks, is available at **www.anthem.com** under SpecialOffers@Anthem.

If You Need Assistance

Medical, Dental, and Prescription Drug Benefits

Administered by Anthem Blue Cross and Blue Shield

- **(804) 355-8506** in Richmond
- **1-800-552-2682** outside Richmond
  Monday through Friday 8:00 a.m. – 6:00 p.m.
  Saturday 9:00 a.m. – 1:00 p.m.
- On the Web at **www.anthem.com**

Mental Health & Substance Abuse Care and Employee Assistance Benefits

Administered by Magellan Behavioral Health

- **1-800-775-5138**
- On the Web at **www.dhrm.state.va.us/services/health/magellan.htm**

The Local Choice

The Local Choice Health Benefits Program
Commonwealth of Virginia
Department of Human Resource Management
101 North 14th Street – 13th Floor
Richmond, VA 23219

- **(804) 786-6460**
- On the Web at **www.thelocalchoice.state.va.us**